

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

31662

State File No.

Registrar's No. 778

FILED OCT 7 1943 128

Primary Registration District No. 2000

1. PLACE OF DEATH:
(a) County **GREENE**
(b) City or town **Springfield**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. John's Hospital
(If not in hospital or institution, write street number or location) **0**
(d) Length of stay: In hospital or institution (Specify whether)
In this community **26 Years**
years, months or days)

3. (a) PRINT FULL NAME **Charles C. McCord**
3. (b) If veteran, name war **no** 3. (c) Social Security No. **Unk.**

0 5. Color or race **White** 6. (a) Single, widowed, married, divorced. **Married**
4. Sex **Male** 6. (b) Name of husband or wife **May Kennedy McCord**
6. (c) Age of husband or wife if alive **Unk.** years
7. Birth date of deceased **Nov. 21 1878**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
64 9 28 hr. min.

9. Birthplace **Stone County Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Salesman**

11. Industry or business **McGregor Hardware Co.**

12. Name **Dr. T.J. McCord**
13. Birthplace **Unk. Arkansas**
(City, town, or county) (State or foreign country)
14. Maiden name **Nancy Carr**
15. Birthplace **Galena Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **May Kennedy McCord**
(b) Address **Springfield, Mo.**

17. (a) **Burial** (b) Date thereof **Sept. 21, 1943**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Maple Park**

18. (a) Signature of funeral director **H.H. Lohmeyer**
(b) Address **Springfield, Mo.**

19. (a) **9-20-43** (b) **R. W. Handley**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo.** (b) County **Greene** 039
(c) City or town **Springfield** 2
(If outside city or town limits, write "RURAL") 6
(d) Street No. **817 N. Jefferson Ave.**
(If rural, give location)
(e) Citizen of foreign country? **No.** (Yes or No)
If yes, name country **0**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept.** day **19**
year **1943** hour **10** minute **20a** M.

21. I hereby certify that I attended the deceased from **8-22-43**
19 to **9-19-43**
that I last saw him alive on **9/19/43**
and that death occurred on the date and hour stated above.

Immediate cause of death **Acute Gangrenous Cholecystitis -**
Duration **48 hrs**

Due to **12781**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy **Acute gangrenous Cholecystitis -**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work (Specify type of place) (c) Means of injury

23. Signature **Rosemary Bosser** (M. D. or other) **Springfield, Mo.** Date signed **9/19/43**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
..... Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

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